REPORT OF THREE YEARS' RECTAL WORK AT THE COUNTY HOSPITAL.*

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My object in writing this paper for your consideration is twofold; first, to invite your attention to the frequency of rectal and colonic diseases; and second, to compare the different methods of operating for said diseases. I have taken from my books and tabulated a list that you may see the frequency with which each disease occurs. All writers on this subject agree that hemorrhoids heads the list. Permit me to say in this connection that much confusion might arise here for the reason that the patient's word is often taken and he invariably calls any, and all, affections in the region of the anal canal or rectum, *piles,* when in truth his opinion is far from being correct. May I also suggest that the doctor in the case frequently falls into error either by taking the patient's word for it, or that he fails to make a thorough examination or perhaps never having given any special study to these diseases, is not prepared to make a positive diagnosis. No one will gainsay but that the diseased conditions found in the rectum and colon are of just as much importance as when disease is found in any other portion of the anatomy. Either one or the other, rectum or colon, is frequently the seat of enough pathologic change as to render life unbearable or endanger life. Let me cite in evidence: Cancer, tubercular ulceration, close strictures of the gut, destructive fistulae, dangerous hemorrhage, and may I add, pruritus and fissure, one the most tormenting, the other the most painful of all affections of the body. I do not include hemorrhoids although many appear to think that they embrace about the only disease found in this region that calls for surgery. And there be those that harken to the charlatan, and argue that ointments are quite sufficient for the cure of "piles." I submit my report which is as follows:

OPERATIONS.

Hemorrhoids	267
Fistulae	116
Abscesses	44
Strictures	21
Irritable ulcers and Fissures	24
Benign Tumors	10
Tubercular ulcers	19
Prolapse	8
Cancers	6
Pruritus Ani	6
Impacted Feces	2
Total	523

As my work at the clinic ward is limited to surgery no "treatment" cases are reported. I will not attempt to individualize these cases for to do so would make this paper too long, but will rather content myself with dealing with them as a whole and dwell more upon the methods of operating, looking to their cure and submitting comparisons. First, let me call your attention to the frequency with which these diseases occur, which I believe will be found about the same by all surgeons doing rectal work, yet I have heard it discussed, whether hemorrhoids or fistula should receive first place. In my records, hemorrhoids so outstrip fistula in the race of frequency that the latter could not be considered a good running mate, although it does come second in the list.

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HEMORRHOIDS.

It is not my intention, as has been intimated, to discuss the etiology of these diseases in this paper but only to deal with them in an operative way. For the relief of hemorrhoids many operations have been devised. The two most used are the ligature and the clamp and cautery. The elder Allingham up to the time of his death, a few years ago, and after doing thousands of operations pronounced the ligature "the best, safest and quickest done" of all operations for hemorrhoids. I have used both methods frequently and although many consider the ligature as obsolete, and nonsurgical, the reasons given, viz: "that it invites sepsis, and that it is the most painful" do not hold good in my work or in the opinion of others who do proctologic work. Allingham counts sepsis as *nil* after ligature operations, and Mathews after thirty-five years in this special line reports that he never saw sepsis result after an operation for hemorrhoids by ligature. (He refers to one death from tetanus in his book.) It stands very favorably with the clamp and cautery method, at least so in my work. You will notice in the list that I have done in the three years in the County Hospital two hundred and sixty-seven operations for hemorrhoids. I have not limited myself to any one of the different advised operations. Indeed there are quite a number suggested. Allingham ligated after making a deep cut at the sulcus or white line leaving the tumor hanging as an isthmus, cutting it off close to the ligature. Mathews did this operation for a number of years, then changed the method to simply cutting through the skin, thereby, he claims, avoiding all hemorrhage. Earle, with a special clamp catches the tumor at its base, cuts it off and sutures around the instrument. Van Buren transfixed the tumor by passing a large threaded needle through the center of the pile and tieing tightly on either side. Pennington excises the tumor, Gant does much of his work under local anesthesia. Almost all others confine themselves to the clamp and cautery. I prefer the plan suggested by Mathews with the addition of a subcutaneous stitch around the cut edge of the skin with the same ligature as suggested by Ball. I think it lessens the pain and shortens convalescence.

FISTULA IN ANO.

Permit me to say that "Fistula in Ano" though used by all authors, is a misnomer. Fistula in this region deals much more with the rectum and its tissues than with the anus. In the three years' service I have operated one hundred and seventeen times for anal or rectal fistulas. In a word, the operation consists in ferreting out each and all sinuses and dissecting them out. In doing this, very often much tissue must be sacrificed. This is the one disease that requires much cutting if a

cure is expected. Better by far to do too much than too little. I never fail to sever the sphincter muscle when necessary. It must not be forgotten too that its action during and following defication prevents the healing process. Being both a voluntary and involuntary muscle it can be in action at any time; no fear should be entertained that incontinence will follow save in the tubercular patient or where the muscle has been injured by traumatism. The patient is allowed to get out of bed and walk much sooner than it takes the wound to heal; this course aids, rather than prevents, the healing process.

ABSCESS.

Strange to say that during the three years I have opened but forty-four rectal abscesses. Recognizing that all fistulas begin with an abscess and that when these are opened in the early stage the fistula is often prevented, this small number can be accounted for by reason of the fact that the patient does not know of the importance of having the trouble attended early and, too, they are often advised by the physician to wait and allow it to "burst." I would rather open the supposed abscess and find only inflammatory tissue, than to allow a pus formation to go a single day without opening.

STRICTURE.

I have operated on twenty-one cases of stricture of the rectum in these three years. You will agree with me I am sure when I say that a stricture of the gut in any locality is a very serious condition. If they are within reach they should be removed by making a dissection of the gut or a posterior linear proctotomy with complete division of external parts. Some practice gradual or forcible dilatation. I have used all of these methods and prefer the first two mentioned. If for any reason it is thought not advisable to operate for the stricture per se then a colostomy should be done. I have had only three cases when I thought this necessary, two of the strictures being the result of malignant disease and the other of syphilitic infection.

IRRITABLE ULCER AND FISSURE

I have listed irritable ulcer, and fissure under the same heading, although they are not the same by any means. A fissure is simply a break or crack in the mucus membrane at the anal outlet. An irritable ulcer is just what the name implies: an ulcer irritated. The surgery required to cure a fissure is very simple; a cut through it and the edges trimmed will effect a cure. In many cases a full dilatation of the muscle is all that is required. An irritable ulcer requires much more than this—full dilatation of the muscle, a curettage of the ulcer, trimming of the edges and many applications afterward. An ulcer in the rectum should be looked upon with suspicion for tuberculosis is often the cause of this condition.

TUBERCULOUS ULCERATION.

And this leads me to consider ulcers that are of tuberculous origin, of these I have seen and treated surgically nineteen cases. If they required any surgery I never hesitated to use it, such as trimming off infected edges, cauterization of the ulcer, etc. One precaution should always be observed in dealing with these cases; namely, be careful in dilating the muscle. The wounds will heal if properly cared for. It would be a pity to leave these cases uncared for, under the mistaken idea that surgery would do no good.

PROLAPSE.

The rectum often prolapses either in the infant, middle, or old age, in size from a very small tumor to one of immense proportions. No treatment outside of surgery does any good for a pronounced case of prolapsus except in the infant when strapping the buttocks will effect a cure. The suggestion of Van Buren, to draw six lines down over the mucous surface of the rectum with the actual cautery has been proven inefficient by all operators. The two accepted operations for the trouble are amputation, and colopexy as devised by Mathews. The latter operation consists in opening the abdomen in the median line, drawing the gut out *taut* and suturing to the abdominal wall. I have done this operation in two cases with very satisfactory results. I have amputated the prolapsed gut several times with a favorable result.

BENIGN TUMOR.

Under the head of benign tumor I include polyps. All such I have removed by ligating at the base and cutting away the tumor if of any size.

PRURITUS ANI.

It is believed by many of our leading proctologists that this troublesome affection should be treated in a surgical way. Mathews does a careful dissection of the itching area made to include the lower inch of the rectum. Hanes removes only the lower inch and claims that this effects the cure. Ball makes a curved incision on each side of the affected area. The flaps are dissected up to the anal canal above the muco-cutaneous junction. And thus all the cutaneous nerves are severed. After bleeding is stopped the flaps are returned in place. The danger that I see in this operation is that after severing the nerve distribution in buttock you might have death of tissue result. In my service I have been content to remove the lower inch only. I believe with those who classify this disease as one requiring surgery, as all other treatment is generally futile, except in very mild cases.

CANCER.

It is a well recognized fact that the rectum is a favored seat for cancer and if seen in its earlier stages is often cured by surgery. Whole volumes could be written concerning the different operations that are proposed for its removal. Every one who has removed the complete rectum for a malignancy will confess I am sure that the operation is one of the major if not *the* major operation in surgery. I have operated six times for a malignant rectum, four are living, one died following the operation, one had a recurrence in the liver in three months. Dr. Cooke kindly operated at my clinic on one case of this kind. Percy has devised a procedure to be used in the advanced cases of cancer, which consists in the application of modified

heat by cautery. In some cases his results have been marvelous. He emphasizes that it is not the cancer that kills the patient, but the sepsis it causes. He believes that his heat application suspends this action.

SEX.

This report covers operations on males four hundred and five, females, one hundred and seventeen, showing a great preponderance of rectal diseases in the male.

ANESTHETICS USED.

Spinal	317
Ether	117
Gas	3
Local	86
Total	523

You will observe that I have used spinal anesthesia principally in my rectal work and I regard it as an ideal anesthetic in such work. I know that this method has been decried by many operators but I must believe that it was not given a fair trial in their hands. I have never lost a case that could be attributed to its use nor have I had any unpleasant experiences so I shall still continue to use it. As all of this work has been done in the wards of a public hospital it has been impossible to collect data as to results.

Discussion.

Dr. Whitman: For more than three years past, all cases of rectal pathology coming to the County Hospital, have been referred to Dr. Kiger. The list of cases presented by him here tonight is compiled from the hospital records of cases operated by him, and is therefore correct. The results of operations have been uniformly good. I have seen Dr. Kiger operate, and I am very favorably impressed with his technic, especially his modifications of the Mathews method, where he stitches the skin and mucosa. This seems to me to give a better result than any other procedure with which I am familiar. You have had the pleasure tonight of listening to an address by Prof. Joseph Mathews of Louisville, who is one of the most distinguished members of our fraternity. I am proud to say that I have known Dr. Mathews for more than a quarter of a century.

Dr. A. B. Cooke: The paper we have just heard read is a particularly admirable one because of its practical nature. I have had the pleasure of visiting Dr. Kiger's clinic a number of times at the County Hospital and I regard it one of the best rectal clinics if not the best of which I have any knowledge.

Many points in the paper would bear discussion did time permit. I shall refer to only one. Dr. Kiger seems to give the weight of his endorsement to the ligature operation for internal hemorrhoids. Performed as they generally are in Dr. Kiger's clinic under spinal anesthesia there is some show of reason for this preference. But as contrasted to the clamp and cautery operation there can be no doubt of the great superiority of the latter. The ligature operation has many defects which can be summed up in the statement that it is an unsurgical procedure. Whatever technic is employed when the base of the tumor is strangulated by ligation there is nothing for it to do but slough. This results in leaving a raw, open, ulcerating surface which invites sepsis. Again we all know that one of the most painful things that can happen in surgery is the compression of sensory nerve filaments with a ligature, thus inviting if not insuring post operative pain. On the contrary, the wound left by the clamp and cautery is aseptic from the beginning, repair is much more prompt, and if the technic is correct the post-operative discomfort is very much lessened. The above comments are made notwithstanding the presence of my very good friend Dr. Mathews. What he will say I know in advance for I have heard it many times. But I am sure it will prove interesting to the audience. I am very glad indeed Dr. Kiger read this paper tonight that the profession of the city may have some knowledge of the good work going on over at our splendid County Hospital.

J. M. Mathews (by invitation). The one thing that has interested me most in this most excellent report of Doctor Kiger's is the fact that he has so large a clinic on this special disease. I speak advisedly when I say that it is the largest and best clinic of its kind to be found anywhere in the United States. The County Hospital, under its splendid management, should be congratulated for providing such rare conditions for patients afflicted with this special class of diseases so much neglected by the general profession.

The next thing that attracted me was the anesthetic that he uses. I must confess that I have never used spinal anesthesia, because I feared it. I must have gotten my impressions from some adverse criticisms in the medical press. I can quite understand now that anything opposed to this method arose during its earlier use, when cocain was the agent used. I would have no further fear after hearing this report.

I am glad that the doctor has mentioned the use of the ligature in operating for hemorrhoids and commends it. Much has been written and talked in opposition to its use. My friend Dr. Cooke has just now in discussion of the paper given several reasons why he opposes its use. Like many who write and talk against it, I fear that the doctor started off in the treatment of hemorrhoids by using the clamp and cautery, which no doubt has served him well, and was prejudiced against the ligature, and has never given it a fair trial. I say this because, after using it for over thirty years, I can safely affirm that one and all of the reasons he gives for not using it are purely chimerical. In all my long experience I have never had a single case of sepsis follow, nor an abscess result. Nor have I ever had an ulcer supervene. The elder Allingham said to me once in St. Mark's Hospital that his experience was similar, after operating thousands of times for this trouble by the ligature. Indeed, he used no other method. So if real facts amount to anything, Doctor Cooke's objections go to naught.

I too regret that Doctor Kiger did not go into the etiology of these diseases, but I can quite understand that it was not in the limits of his paper. He is to be congratulated in presenting to this society so practical a paper.